

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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12093

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS Bayside Beach	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anne (Anne) Middle A. Last ADAMS		4. DATE OF DEATH Month November Day 28 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew B. Sheridan		14. MOTHER'S MAIDEN NAME Rose Anne Malore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-28-2773	
17. INFORMANT Mrs. L. V. Itzoe, New Freedom, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral stenosis to lungs of 170X DUE TO Carotid artery heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) — (c) —		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the hospital attended the deceased from Nov. 16, 1960 to Nov. 28, 1960 , that (I) (we) last saw the deceased alive on Nov. 28, 1960 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 11/28/60	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1960	
23c. NAME OF CEMETERY OR CREMATORY St. John R. C. Cem.		23d. LOCATION (City, town, or county) (State) New Freedom, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Jacob K. Kasten		25a. REC'D BY REGISTRAR DEC 2 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kras			

12111

CERTIFICATE OF DEATH

Name of Deceased

Age

Sex

Date of Death

Place of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Deceased

Signature of Witness

Signature of Minister

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

VS. A15ME
5M 7/59

(M)

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
12159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12094														
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel					b. COUNTY Cape May County									
c. LENGTH OF STAY IN lb 30 minutes					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel Race Track					d. STREET ADDRESS 941 Bay Ave.									
3. NAME OF DECEASED (Type or print) Avis G. Allen					4. DATE OF DEATH Nov. 11th. 1960									
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/10/99		9. AGE (In years last birthday) 61 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Leesburg, N.J.		12. CITIZEN OF WHAT COUNTRY? USA		13. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME John Abel					14. MOTHER'S MAIDEN NAME Abbie Chance									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) No					16. SOCIAL SECURITY NO. ?					17. INFORMANT Mr. Walter J. Allen				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH Sudden				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Gustave H. Faubert M.D. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Gustave H. Faubert M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/11/60 Address (Street, city, town, or county) Glen Burnie, Md.														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov 16, 1960		22c. NAME OF CEMETERY OR CREMATORY Leesburg Methodist		22d. LOCATION (City, town, or country) Leesburg New Jersey						
23. FUNERAL DIRECTOR Address W. W. With Donaldson, Laurel, Maryland						24a. REC'D BY REGISTRAR DATE NOV 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume						

12131

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THE
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DEPARTMENT OF
AGRICULTURE
WASHINGTON, D. C.
1913



12131

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12160
CERTIFICATE OF DEATH

12095

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.	c. LENGTH OF STAY IN 1b 33 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School Children's Center		d. STREET ADDRESS 470 - N Street S.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Alice Middle Anderson Last Anderson		4. DATE OF DEATH Month November Day 20 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1885
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert Anderson	
14. MOTHER'S MAIDEN NAME Alice Anderson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. --		INFORMANT Address Children's Center, Laurel, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental retardation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- -- -- --	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **November 57**, to **Nov. 20, 60**, that I last saw the deceased alive on **Nov. 20, 1960**, and that death occurred at **5:45 AM**, from the causes and on the date stated above.

ACTUAL SIGNATURE **James E. Boyland** M.D. ADDRESS (Street, city or town, state) **Children's Center, Laurel, Md.** DATE SIGNED **11/21/60**
 PHYSICIAN'S NAME (Type) **James E. Boyland** **Children's Center, Laurel, Md. 11/21/60**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-22-60	22c. NAME OF CEMETERY OR CREMATORY Cox Funeral Home	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Willie Nees - 3001 1st Ave Wash D.C.		24a. REC'D BY REGISTRAR DATE NOV 22 '60	24b. REGISTRAR'S SIGNATURE Arthur E. Hanna

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12119
CERTIFICATE OF DEATH

12096

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Harwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Hudson Last ARMIGER				4. DATE OF DEATH Month November Day 9 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 8, 1960	
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 1 Days 5 Hours 20 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME James Kenneth ARMIGER				14. MOTHER'S MAIDEN NAME Ruth Estelle PRENDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 754.5 IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PREMATURITY				INTERVAL BETWEEN ONSET AND DEATH 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from Nov. 8, 1960 , to Nov. 9, 1960 , that (I) (we) last saw the deceased alive on Nov. 9, 1960 , and that death occurred at 1:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Stuart H. Walker				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stuart H. Walker				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 11, 1960		23c. NAME OF CEMETERY OR CREMATORY Woodfield	
23d. LOCATION (City, town, or county) (State) Walesville Md.				23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardaty Silverville Md.				25a. REC'D BY REGISTRAR DATE NOV 21 '60		25b. REGISTRAR'S SIGNATURE Charles L. Hines	

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CERTIFICATE OF DEATH

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12120

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 19 Cathedral Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 Cathedral Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First BERNARD F Middle BASIL Last BASIL		4. DATE OF DEATH Month NOVEMBER Day 5 Year 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1885	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 5 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk		10b. IND. OF BUSINESS OR INDUSTRY Maryland Governors Office	
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Fletcher Basil		14. MOTHER'S MAIDEN NAME Elizabeth Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 05 1767		17. INFORMANT Mrs Nellie I. Basil- Wife- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate gland with metastases to spine DUE TO (b) 6 months DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. Month 19 Day 11 Year 1960 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis		(County) Anne Arundel		(State) Md.	
21. I certify that I attended the deceased from Jan 10, 1960 to 11-5-1960 , that I last saw the deceased alive on 11-4-1960 , and that death occurred at 4:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Shaw Street, Annapolis, Md.		DATE SIGNED 11-7-60					
ACTUAL SIGNATURE James R. Martin		M.D. James Martin MD					
PHYSICIAN'S NAME (Type) James Martin MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR NOV 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12098

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 118 O'Berry Court				d. STREET ADDRESS 118 O'Berry Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KYLE Middle ROBBIE Last BELT				4. DATE OF DEATH Month November Day 24 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2-60	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 11 Days 22		IF UNDER 24 HRS. Hours 22 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Annapolis, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George W. Belt				14. MOTHER'S MAIDEN NAME Lillian Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George W. Belt- 118 Obery Court-Anna.Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/25/60 ACTUAL SIGNATURE W. Bradley King, Jr., M.D. EXAMINER'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11-26-60 22c. NAME OF CEMETERY OR CREMATORY Brewer Hill 22d. LOCATION (City, town, or country) (State) Annapolis, Md. 23. FUNERAL DIRECTOR ADDRESS C.E.Hicks 111 Annapolis, Maryland 24a. REC'D BY REGISTRAR DA DEC 1 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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Journal of Management, 25(4), 451-464.

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11-10-50

[illegible]

12099

12122

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. Co. Gen'l - Hospital</u>				d. STREET ADDRESS <u>Rt 10 - Box 358 (Vassanig)</u>			
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>Louis</u> Last <u>Bender</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>25 Feb 1901</u>	
9. AGE (In years last birthday) <u>59 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian (Ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co. Bd. of Educa.</u>			
11. BIRTHPLACE (State or foreign country) <u>Fort Wayne Indiana</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Walter Bender</u>				14. MOTHER'S MAIDEN NAME <u>Soppia Hannick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>218-10-4801</u>			
17. INFORMANT <u>Mrs. Philomena Bender - Same As #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHO-PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>MASSIVE CEREBRAL HEMMORHAGE</u> DUE TO (c) <u>HYPETENSIVE CARDIOVASCULAR DISEASE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>72 HRS.</u> <u>4 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>AUGUST</u> , 19 <u>56</u> , to <u>NOV. 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>NOV. 15</u> , 19 <u>60</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2934 MOUNTAIN RD.</u> DATE SIGNED <u>11-16-60</u>							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>				M.D. <u>2934 MOUNTAIN RD.</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>				<u>PASADENA, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>19 Nov 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 21 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12122

12000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

THE DAY OF

DATE OF DEATH

DECEASED

PLACE OF DEATH

PLACE OF BIRTH

AGE

SEX

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

12123

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12100

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.H. GENERAL Hospital		d. STREET ADDRESS 1 608 SEVERN AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle E Last BENNETT		4. DATE OF DEATH Month 11 Day 2 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1920
9. AGE (In years lost birthday) 40 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME ROBERT F. REVELL		14. MOTHER'S MAIDEN NAME MABEL H. STARR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT THOMAS E. BENNETT Address #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma, metastatic, left groin DUE TO (b) Squamous cell carcinoma, left mid-toe. DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 24, 1960 to Nov. 2, 1960 that (I) (we) last saw the deceased alive on Nov. 2, 1960 and that death occurred at 9:15 PM from the causes and on the date stated above.			
22a. SIGNATURE Francis I. Codd M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 11-2-60	
22c. PHYSICIAN'S NAME (Type) Francis I. Codd		22d. ADDRESS Severna Park, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-5-60	
23c. NAME OF CEMETERY OR CREMATORY EDWARDS Chapel		23d. LOCATION (City, town, or county) (State) Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Byrnes ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR NOV 7 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12124
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12101

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Tracys Landing	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Meda Middle S. Last BINGHAM		4. DATE OF DEATH Month November Day 15 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1882
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lewis Wm Spies		14. MOTHER'S MAIDEN NAME Belle Below	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Colonel K. Bingham	
17. INFORMANT Colonel K. Bingham		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) central thrombosis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) myocardial & renal insufficiency (c) generalized arteriosclerosis with hypotension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from Oct. 16, 1960 to Nov. 15, 1960 , that (I) (he) last saw the deceased alive on Nov. 15, 1960 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Emily H. Wilson		22b. DATE SIGNED 11/16/60	
22c. PHYSICIAN'S NAME (Type) Emily H. Wilson		22d. ADDRESS Lothian, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-18-1960	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City, town, or county) (State) Roznoke Va.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		25a. REC'D BY REGISTRAR NOV 21 '60	
ADDRESS Annapolis Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1912

1912

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored and difficult to read.

Robert H. Thompson (2)

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12161

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12102

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Baltimore 25</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5317 Ritchie Highway</u>				d. STREET ADDRESS <u>5317 Ritchie Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Angeline Lena Bohlman</u>				4. DATE OF DEATH Month Day Year <u>Nov. 30, 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28 Aug., 1885</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Miexner</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-6665B</u>		17. INFORMANT <u>Herman Bohlman, Same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, chronic</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>175.0</u> DUE TO (c) <u>175.0</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>175.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>10-9-60</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 11-25, 1960</u> to <u>November 19, 1960</u> , that (I) (we) last saw the deceased alive on <u>11-25</u> 19 <u>60</u> , and that death occurred at <u>10:50</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>C. R. MacDonald M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-2-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. R. MacDonald, M.D.</u>				22d. ADDRESS <u>204 Crain Hwy. SW, Glen Burnie, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 Dec., 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore City, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

15101

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF MARITIME SERVICE
OFFICE OF MARITIME SAFETY

15101

Form with multiple sections and fields, including checkboxes and text areas. The text is mirrored and difficult to read, but appears to be a standard maritime safety form.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12162

CERTIFICATE OF DEATH

12103

Items 8 & 9, Film G0276 12/15/60.cac.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>211 Kent Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>J.</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Julius Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Narrod</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-075091</u>	
17. INFORMANT <u>Mrs. Patrick</u>		Address <u>211 Kent Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>Arteriosclerosis</u> (c) <u>General</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1959</u> to <u>Nov 18</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 5</u> , 19 <u>60</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Taler</u>		22b. DATE SIGNED <u>Nov 19, 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH TALER</u>		22d. ADDRESS <u>102 B & Bldg. N.E. Glen Burnie</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-22-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Anne Arundel, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Stevens</u>		ADDRESS <u>1501 E. Port Ave.</u>	
25a. REC'D BY REGISTRAR <u>Nov 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Evans</u>	

15103

CERTIFICATE OF MARRIAGE

15103



12163

CERTIFICATE OF DEATH

Reg.-Dist. No. 23 -

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Carl</u> Last <u>Burkowske</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tractor for D.O. P.D.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam Burkowske</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Mrs. M. M. Galt</u>		Address <u>404 Delmar Ave Glen Burnie</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Influenza</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u> <u>—</u> <u>—</u>
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>60</u> , to <u>Nov 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>60</u> , and that death occurred at <u>11:07 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Billingsh</u>		ADDRESS (Street, city or town, state) <u>118 Centon Ave Glen Burnie Md</u>	
PHYSICIAN'S NAME (Type) <u>James S. Billingsh M.D.</u>		DATE SIGNED <u>Nov 25, 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>28-NOV-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore City Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>RKS</u>		ADDRESS <u>Glen Burnie, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>DEC 5 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12163

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

12163

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1873		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
Carpenter		Heart Disease		Natural		Several days		JAN 20 1918		BALTIMORE		MD		USA	
PREVIOUS ILLNESS		DATE OF EXAMINATION		BY		DATE OF INTERMENT		BY		DATE OF BURIAL		BY		DATE OF CREMATION	
None		JAN 20 1918		J. H. HARRIS		JAN 22 1918		J. H. HARRIS		JAN 22 1918		J. H. HARRIS		JAN 22 1918	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 20 1918		BALTIMORE		MD		USA				JAN 20 1918		BALTIMORE		MD	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 20 1918		BALTIMORE		MD		USA				JAN 20 1918		BALTIMORE		MD	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12125

12106

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Reed Last BURRELL		4. DATE OF DEATH Month November Day 29 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 23, 1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 9 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Illinois	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Reed		14. MOTHER'S MAIDEN NAME Julia Muzzy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 222-09-8487	
17. INFORMANT Donald W. Burrell		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder - terminal DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Nov. 19, 19 60 to Nov. 29, 19 60 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on Nov. 29, 19 60 , and that death occurred at 1:40 P.M. M. from the causes and on the date stated above.			
22a. SIGNATURE Jesse L. Wilkins		22b. DATE 11/29/60	
22c. PHYSICIAN'S NAME (Type) Jesse L. Wilkins		22d. ADDRESS 100 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-1-60	
23c. NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Pk.		23d. LOCATION (City, town, or county) (State) Farnhurst, Delaware	
24. FUNERAL DIRECTOR'S SIGNATURE William J. Warwick		25a. REC'D BY REGISTRAR DEC 1 '60	
ADDRESS Newark, Dela.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

WILLIAM J. WARWICK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12164

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12107

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 9 years 5mo. 11 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomeo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Unknown		4. DATE OF DEATH Month 11 Day 18 Year 1960		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
3. NAME OF DECEASED (Type or print) First Louis Middle Anthony Last Burton		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1901		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) TBc of Lungs DUE TO (c) Central Nervous System Syphilis, General Paresis		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> while not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/7 1951 to 11/18 1960 , that (I) (we) last saw the deceased alive on 11/18 1960 , and that death occurred at P. M. from the causes and on the date stated above.		22a. SIGNATURE Hildegard Heard Reissman		22b. DATE 11/21/60		22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Md.		22e. DATE 11/21/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/1960		23c. NAME OF CEMETERY OR CREMATORY Quantico		23d. LOCATION (City, town, or county) (State) Quantico Md		24. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart Salisbury Md.		25a. REC'D BY REGISTRAR NOV 28 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. DATE NOV 28 1960		25d. ADDRESS -----		25e. CITY OR TOWN -----		25f. STATE -----		25g. ZIP CODE -----	

4157

1890-1891

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
12126
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12108

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRO GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park, Md 16712</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMewood NURSING HOME</u>		d. STREET ADDRESS <u>4506 - College Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELOISE</u> Middle <u>PETRIE</u> Last <u>CLAFLIN</u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 5 - 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>16</u> Min.	IF UNDER 24 HRS. Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick O. Petrie</u>		14. MOTHER'S MAIDEN NAME <u>Nora Moeller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. E. Louis Mendel</u>		Address <u>College Park Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ARTERY THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>55</u> , to <u>11/7</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/6</u> 19 <u>60</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard N. Peeler</u>		22b. DATE SIGNED <u>Nov 7 - 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		22d. ADDRESS <u>ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Nov 10, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Buscha Sons</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>	
ADDRESS <u>Hyattsville Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

80132

U.S. DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.

12150

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Certificate" and "No." are faintly visible.]

①

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13328

12165

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BRUCE</u> Middle <u>TED</u> Last <u>COLLINS JR.</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>N/A</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 Nov 60</u>
9. AGE (In years last birthday) <u>5</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>32</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME <u>Bruce T. Collins</u>		14. MOTHER'S MAIDEN NAME <u>Jackie Latture</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT <u>Medical Records USA Hosp Ft G G Meade, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>30 Nov 1960</u> to <u>30 Nov 1960</u> , that (I) (we) last saw the deceased alive on <u>30 Nov 1960</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Sherman S. Robinson Capt. M.C.</u>		22b. DATE SIGNED <u>30 Nov 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>SHERMAN S. ROBINSON, Capt., M.C.</u>		22d. ADDRESS <u>USA Hosp Ft Geo G. Meade, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/3/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sprules Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Benham, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. MacDonald, Laurel, Md.</u>		25. REC'D BY REGISTRAR DATE <u>DEC 9 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>			

1958

LABORATORY OF THE DISTRICT ATTORNEY
IN CHARGE OF THE DISTRICT ATTORNEY
DISTRICT OF COLUMBIA

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12127

CERTIFICATE OF DEATH

12109

Item 7 11-14-60 et

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 2 Southgate Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Katharine Last COX		4. DATE OF DEATH Month November Day 6 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1895
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 6 Hours 1960	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jerome A Cox		14. MOTHER'S MAIDEN NAME Lillian Rockhold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Jerome Cox		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 YRS DUE TO (c) 5 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 HOURS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) at hospital attended the deceased from 5 Nov 1960 to Nov. 6, 1960 , that (I) was last saw the deceased alive on Nov. 6, 1960 , and that death occurred at 10:55 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck M.D.		22b. DATE SIGNED 11/7/60	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 71 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-9-1960	
23c. NAME OF CEMETERY OR CREMATORY Preston Cemetery		23d. LOCATION (City, town, or county) (State) Preston Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Taylor Sons		25a. RECEIVED BY REGISTRAR DATE NOV 9 '60	
ADDRESS Annapolis Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

18181

CERTIFICATE OF DEATH

18181

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF WITNESSES

(2)

James J. [illegible]
[illegible]

James J. [illegible]

12110

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
c. LENGTH OF STAY IN 1b <u>8 yrs.</u>				d. STREET ADDRESS <u>1 301 Burnside St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>301 Burnside St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>T.</u> Last <u>Crane</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1867</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas E. Maley</u>				14. MOTHER'S MAIDEN NAME <u>"Unknown"</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Jacob L. Crane</u>		17. INFORMANT Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1956</u> to <u>Nov. 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>60</u> , and that death occurred at <u>8:20</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John H. Hedeman</u> M.D. <u>121 CATHEDRAL ST. ANNAPOLIS MD 21403</u> PHYSICIAN'S NAME (Type) <u>JOHN H. HEDEMAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-5-1960</u>		<u>Calvary Cemetery</u>		<u>Evanston, Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Taylor & Sons Annapolis, Md.</u>				24. REC'D BY REGISTRAR DATE <u>DEC 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12110

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

12110

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. EDUCATION High School Graduate		12. RELIGION Methodist		13. MANNER OF DEATH Suicide		14. CAUSE OF DEATH Self-inflicted gunshot wound		15. PLACE OF DEATH Room 936, Lorraine Motel, Memphis, Tennessee	
16. DATE OF DEATH April 4, 1968		17. TIME OF DEATH 2:01 PM		18. PLACE OF DEATH Room 936, Lorraine Motel, Memphis, Tennessee		19. NAME OF PHYSICIAN Dr. J. H. Hume		20. NAME OF HOSPITAL None	
21. NAME OF FUNERAL HOME None		22. NAME OF BURIAL PLACE None		23. NAME OF CEMETERY None		24. NAME OF INTERMENT PLACE None		25. NAME OF INTERMENT PLACE None	
26. NAME OF INTERMENT PLACE None		27. NAME OF INTERMENT PLACE None		28. NAME OF INTERMENT PLACE None		29. NAME OF INTERMENT PLACE None		30. NAME OF INTERMENT PLACE None	
31. NAME OF INTERMENT PLACE None		32. NAME OF INTERMENT PLACE None		33. NAME OF INTERMENT PLACE None		34. NAME OF INTERMENT PLACE None		35. NAME OF INTERMENT PLACE None	
36. NAME OF INTERMENT PLACE None		37. NAME OF INTERMENT PLACE None		38. NAME OF INTERMENT PLACE None		39. NAME OF INTERMENT PLACE None		40. NAME OF INTERMENT PLACE None	
41. NAME OF INTERMENT PLACE None		42. NAME OF INTERMENT PLACE None		43. NAME OF INTERMENT PLACE None		44. NAME OF INTERMENT PLACE None		45. NAME OF INTERMENT PLACE None	
46. NAME OF INTERMENT PLACE None		47. NAME OF INTERMENT PLACE None		48. NAME OF INTERMENT PLACE None		49. NAME OF INTERMENT PLACE None		50. NAME OF INTERMENT PLACE None	
51. NAME OF INTERMENT PLACE None		52. NAME OF INTERMENT PLACE None		53. NAME OF INTERMENT PLACE None		54. NAME OF INTERMENT PLACE None		55. NAME OF INTERMENT PLACE None	
56. NAME OF INTERMENT PLACE None		57. NAME OF INTERMENT PLACE None		58. NAME OF INTERMENT PLACE None		59. NAME OF INTERMENT PLACE None		60. NAME OF INTERMENT PLACE None	
61. NAME OF INTERMENT PLACE None		62. NAME OF INTERMENT PLACE None		63. NAME OF INTERMENT PLACE None		64. NAME OF INTERMENT PLACE None		65. NAME OF INTERMENT PLACE None	
66. NAME OF INTERMENT PLACE None		67. NAME OF INTERMENT PLACE None		68. NAME OF INTERMENT PLACE None		69. NAME OF INTERMENT PLACE None		70. NAME OF INTERMENT PLACE None	
71. NAME OF INTERMENT PLACE None		72. NAME OF INTERMENT PLACE None		73. NAME OF INTERMENT PLACE None		74. NAME OF INTERMENT PLACE None		75. NAME OF INTERMENT PLACE None	
76. NAME OF INTERMENT PLACE None		77. NAME OF INTERMENT PLACE None		78. NAME OF INTERMENT PLACE None		79. NAME OF INTERMENT PLACE None		80. NAME OF INTERMENT PLACE None	
81. NAME OF INTERMENT PLACE None		82. NAME OF INTERMENT PLACE None		83. NAME OF INTERMENT PLACE None		84. NAME OF INTERMENT PLACE None		85. NAME OF INTERMENT PLACE None	
86. NAME OF INTERMENT PLACE None		87. NAME OF INTERMENT PLACE None		88. NAME OF INTERMENT PLACE None		89. NAME OF INTERMENT PLACE None		90. NAME OF INTERMENT PLACE None	
91. NAME OF INTERMENT PLACE None		92. NAME OF INTERMENT PLACE None		93. NAME OF INTERMENT PLACE None		94. NAME OF INTERMENT PLACE None		95. NAME OF INTERMENT PLACE None	
96. NAME OF INTERMENT PLACE None		97. NAME OF INTERMENT PLACE None		98. NAME OF INTERMENT PLACE None		99. NAME OF INTERMENT PLACE None		100. NAME OF INTERMENT PLACE None	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased or by the coroner or other qualified person who has examined the body of the deceased. It is to be filled out in duplicate, one copy to be retained by the physician or other qualified person who has attended the deceased or by the coroner or other qualified person who has examined the body of the deceased, and the other copy to be forwarded to the State Department of Health, Baltimore, Maryland.

12166

MEDICAL CERTIFICATION

VR A1S (4)
15M 9/59

12115

OFFICE OF DEATH

12115

Married

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[Faint, mostly illegible text covering the lower half of the page, possibly a list or index.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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12113

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gibson Island</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nina</u> Middle <u>Poe</u> Last <u>Elder</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-7-1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>N. Poe Neilson</u>				14. MOTHER'S MAIDEN NAME <u>Alice Minis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Sarah Elder Symington</u> Address <u>Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the left breast</u> <u>170X</u> DUE TO (b) <u>with metastases</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 11, 1960</u> to <u>Nov. 2, 1960</u> , that (I) met last saw the deceased alive and <u>October 15, 1960</u> , and that death occurred at <u>9:40 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R. M. McLaughlin</u>				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 2, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-5-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>				ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 4 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. P...</u>			

12167

CERTIFICATE OF DEATH

12167

NAME (PRINT)

AGE

SEX

1901

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

SEX

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PLACE OF DEATH

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 5/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12114

12129

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 1 Carvel Hall Hotel	
3. NAME OF DECEASED (Type or print) First Janie Middle E. Last FELDMAYER		4. DATE OF DEATH Month November Day 22 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13th 1872
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gottlieb Feldmeyer		14. MOTHER'S MAIDEN NAME Dorothy Obery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 530 E. 23rd St New York City	
17. INFORMANT Mrs. Edward J. McQuiston		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) generalized arteriosclerosis (c) Arteriosclerosis from inclusion of CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Congestive failure.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 18 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Sept 15th 1959 to Nov. 22, 1960 , that (I) (we) last saw the deceased alive on Nov. 22, 1960 , and that death occurred at 12:30 from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 11/22/60	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 25 1960	
23c. NAME OF CEMETERY OR CREMATORY St Annes Cem		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Scyler Sins		25a. REC'D BY REGISTRAR NOV 28 '60	
ADDRESS Annapolis Md.		25b. REGISTRAR'S SIGNATURE Arthur E. Hwang	

11111

STATE OF TEXAS

11111

County of _____

State of _____

County of _____

State of _____

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State of _____

1

12130

CERTIFICATE OF DEATH

12115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>0 Annapolis (Winchester)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospt.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>15 Riverdale Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>H.</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-2-1915</u>	
9. AGE (In years lost birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph H Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Mathews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-07-3796</u>		INFORMANT <u>Mrs. Betty C. Fisher</u> Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>15-30 min.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>1957</u> , to <u>1960</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>60</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park, Maryland</u> DATE SIGNED <u>11-18-</u>							
ACTUAL SIGNATURE <u>Francis I. Codd</u>				PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>				ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 21 1960</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12115

CERTIFICATE OF DEATH

12130

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ANNE ARCADE

THE ANNE ARCADE HOUSE

THE ANNE ARCADE HOUSE

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STANLEY ARCADE

12116

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 1/2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael		4. DATE OF DEATH November 28 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1960	
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR: Months 1 Days 12 Hours 50	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		12. BIRTHPLACE (State or foreign country) Maryland	
13. CITIZEN OF WHAT COUNTRY? U.S.		14. FATHER'S NAME Stanley Joseph GESEK, Jr.	
15. MOTHER'S MAIDEN NAME Mary Magdelene THOMAS		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
17. SOCIAL SECURITY NO. NONE		18. INFORMANT Address Hospital records.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Failure of Circulation or Respiration 1 1/2 days (c) Failure of Circulation or Respiration 1 1/2 days		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Clayton Norton attended the deceased from Nov. 26, 1960 to Nov. 27, 1960 , that (I) (we) last saw the deceased alive on Nov. 27, 1960 , and that death occurred at 4:30 A.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Clayton Norton		22b. DATE SIGNED 11/29/60	
22c. PHYSICIAN'S NAME (Type) Clayton Norton		22d. ADDRESS Medical Bldg., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 29-NOV-60	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City, town, or county) (State) Glen Burnie Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hearn		25. REC'D BY REGISTRAR DEC 5 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hearn		25c. REGISTRAR'S SIGNATURE	

15116

15116

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

1. PLACE OF DEATH a. COUNTY <i>Anne arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Edgewater Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Homewood Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Wilma</i> Middle <i>Gless-</i> Last <i>Gless-</i>		4. DATE OF DEATH Month <i>11</i> Day <i>26</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 13, 1882</i>
9. AGE (In years last birthday) <i>79 78</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Ohio</i>
10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>L C Hoopes</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Francis Glass Jr</i>		Address <i>Edgewater Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>generalized arteriosclerosis</i> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 26, 1959</i> to <i>Nov. 26, 1960</i> , that I last saw the deceased alive on <i>Nov. 26, 1960</i> , and that death occurred at <i>8:58 A M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Emily H. Wilson</i> M.D.		DATE SIGNED <i>11-26-60</i>	
PHYSICIAN'S NAME (Type) <i>Emily H Wilson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 29, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F Gasch's Sons Hyattsville Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 29 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12133
CERTIFICATE OF DEATH

12118

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>H.A.-Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bay Ridge, MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ludlow Rd.</u>				d. STREET ADDRESS <u>160 RIVERVIEW DR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>SHEA</u> Last <u>HARTIG</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-21-1898</u>		9. AGE (In years last birthday) <u>62</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DANIEL J. SHEA</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE B. GOUDGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>S. DALE Scott</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. carcinomatosis</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of cervix; uteri</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>7 7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1951</u> , 19 <u> </u> to <u>11/8/</u> 19 <u>60</u> , that I last saw the deceased alive on <u>11/8/60</u> , 19 <u> </u> , and that death occurred at <u>12 N.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>S. Borssuck</u>				M.D. <u>Amos Garrett Blvd.</u> <u>11/11/60</u>			
PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u>				<u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-11-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE B. HUFF</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

12119

CERTIFICATE OF DEATH

Reg. Dist. No.

12134

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1951 Drew Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Francis Last Haste		4. DATE OF DEATH Month November Day 24 Year 19 60	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20-1902
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Kimble	
14. MOTHER'S MAIDEN NAME Katie Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Marion Gunn - 1951 Drew St. Anna. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171 X DUE TO Brain tumor Ca. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Ca. & brain DUE TO (c) 1/yr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 6 mos 1/yr.
21. I certify that I attended the deceased from 11/23 , 19 60 , to 11/24 , 19 60 , that I last saw the deceased alive on 11/24 , 19 60 , and that death occurred at 8 A. M. from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE Theodore H. Johnson		ADDRESS (Street, city or town, state) DATE SIGNED 37 Calvert St., Annapolis, Md.	
PHYSICIAN'S NAME (Type) Theodore H. Johnson, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-28-60	22c. NAME OF CEMETERY OR CREMATORY U.S. National	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III		24. REGISTRAR'S SIGNATURE Arthur S. Howard	
ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 5 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12118

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12118

Name of Deceased

Age

Sex

Color

Marital Status

Occupation

Date of Birth

Date of Death

Place of Birth

Place of Death

Cause of Death

Immediate Cause

Intermediate Cause

Underlying Cause

1

2

3

4

5

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Place of Burial

Place of Interment

Death occurred at residence of Deceased

Death occurred elsewhere

Death occurred in transit

Signature of Deceased

Signature of Next of Kin

Signature of Agent

Signature of Agent

Signature of Agent

Signature of Agent

Signature of Agent

Signature of Agent

Signature of Agent

Signature of Agent

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12120

12168

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>King</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 mo, 22 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>CROWN- VILLE STATE HOSPITAL, ville, Md</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buttertown, Worton Rd, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>HENRY</u> First Middle Last <u>ASBURY</u>		4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-1873</u> 9. AGE in years last birthday <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Henry Asbury</u>		14. MOTHER'S MAIDEN NAME <u>Catherine (last name unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Medical Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>023X</u> DUE TO <u>Imatition and Dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Syphilitic arteriosclerotic heart</u> (c) <u>dissect.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CMS associated E.C.N.S. Syphilis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/15/60</u> to <u>11/6</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11/6</u> 19 <u>60</u> , and that death occurred at <u>4:25 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT</u>		22d. ADDRESS <u>Crownsville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-10-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chestertown</u>	23d. LOCATION (City, town, or county) (State) <u>Chestertown Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Michael R. Williams</u> ADDRESS <u>322 Schuler St.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 10 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

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(M)

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AP

12180

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS
BOSTON, MASSACHUSETTS

CERTIFICATE OF DEATH

12180

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of attending physician
9. Signature of registrar
10. Date of registration

11. Name of informant

12. Signature of informant
13. Date of registration

14. Name of registrar
15. Date of registration

12169

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>				c. LENGTH OF STAY IN 1b <u>25 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2112 MARY AVENUE</u>				d. STREET ADDRESS <u>2112 MARY AVENUE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILEY</u> Middle <u>HENRY</u> Last <u>HOFFMAN</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/12/88</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STREET CAR</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILEY H. HOFFMAN</u>				14. MOTHER'S MAIDEN NAME <u>LAURA STEVENS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-10-2510</u>		17. INFORMANT Address <u>MRS. MOLLY HOFFMAN SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>5 YEARS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>NOV. 1, 1960</u> , to <u>NOV. 16, 1960</u> , that I last saw the deceased alive on <u>NOV. 11, 1960</u> , and that death occurred at <u>2:12</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u>				ADDRESS (Street, city or town, state) <u>8471 FT. SMALLWOOD RD. PASADENA, MD.</u>			
DATE SIGNED <u>11/16/60</u>							
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClurey-130 E. Fort Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12135

CERTIFICATE OF DEATH

12122

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle Eileen Last Ingersoll				4. DATE OF DEATH Month Nov. Day 11 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1960	
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		11. BIRTHPLACE (State or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Annapolis Maryland	
13. FATHER'S NAME Robert W. Ingersoll				14. MOTHER'S MAIDEN NAME Charlotte Marie Chaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Robert Ingersoll		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 Nov 19 60 to 11 Nov 19 60 , that (I) (we) last saw the deceased alive on 11 Nov 19 60 , and that death occurred at 9:55 PM, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Stuart Walker				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12 Nov 60	
22c. PHYSICIAN'S NAME (Type) Dr. Stuart Walker				22d. ADDRESS 121 Cathedral St. Annapolis, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12 Nov. 1960		23c. NAME OF CEMETERY OR CREMATORY Epiphany Church Cem.		23d. LOCATION (City, town, or county) (State) Odenton Md	
24. FUNERAL DIRECTOR'S SIGNATURE Glen Burnie				ADDRESS Glen Burnie, Maryland		25a. REC'D BY REGISTRAR NOV 16 60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas				25c. REGISTRAR'S NAME Arthur S. Thomas			

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Dr. Stuart Bell

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

12170

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12123

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2mo. 1 year 15 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First William Middle Geter Last Jackson		4. DATE OF DEATH Month 11 Day 19 Year 1960		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown		8. DATE OF BIRTH August 27, 1876		9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility and Cachexia DUE TO (c) -----												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----															
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----		21. I certify that (I) (this hospital) attended the deceased from 9/4 to 11/19 19 60 , that (I) (we) lost saw the deceased alive on 11/19 19 60 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE 11/21/60		22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/28/60		23c. NAME OF CEMETERY OR CREMATOR University of Maryland Balt. Md.		23d. LOCATION (City, town, or county) Balt. Md.		23e. (State) Md.									
24. FUNERAL DIRECTOR'S SIGNATURE William Reese Ann. Md.		24a. ADDRESS -----		25a. REC'D BY REGISTRAR NOV 29 '60		25b. REGISTRAR'S SIGNATURE William S. Fausch		25c. DATE NOV 29 '60									

07151

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12130 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.M.-Anne Arundel General</u>				d. STREET ADDRESS <u>600 CONDON TERRACE, S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>D.</u> Last <u>Sanison</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 3, 1914</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>8</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Theresa Sanison</u> Address <u>600 Condon Terrace, Washington D.C.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull -</u> <u>812 X</u> DUE TO <u>Excessive Alcohol Usage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - Route 2 - Pedestrian</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11-8</u> 19 <u>60</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>ARCO.</u> (County) <u>MD.</u> (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>11. 8. 60.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-15-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT.</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON VIRGINIA</u>	
23. FUNERAL DIRECTOR ADDRESS <u>W. ERNEST JORDIS Co. 1432 You St. NW</u>				24a. REC'D BY REGISTRAR <u>NOV 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

15130

15130

Handwritten signature

a

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12171
CERTIFICATE OF DEATH

12125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cabot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ANDREW</u> First <u>JOHNSON</u> Middle Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Liberty Bell Ticker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Employee</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Anne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Ethel J. Mattingly - Brooklyn Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/25</u> , 19 <u>60</u> , to <u>11/27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/25</u> , 19 <u>60</u> , and that death occurred at <u>6:15</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Rubin</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>203 Patapeco</u> <u>11/27/60</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL RUBIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 29, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Solomon Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Solomon-Cabot Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 29 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1913

1913

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1880</u></p>		<p>4. Place of birth: <u>Johns Hopkins</u></p>	
<p>5. Date of death: <u>Dec 1, 1913</u></p>		<p>6. Place of death: <u>Johns Hopkins</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Duration of illness: <u>10 days</u></p>	
<p>9. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Name of undertaker: <u>Johns Hopkins</u></p>	
<p>11. Name of informant: <u>John Doe</u></p>		<p>12. Address of informant: <u>Johns Hopkins</u></p>	
<p>13. Signature of informant: <u>[Signature]</u></p>		<p>14. Signature of physician: <u>[Signature]</u></p>	
<p>15. Date of certificate: <u>Dec 1, 1913</u></p>		<p>16. Place of certificate: <u>Johns Hopkins</u></p>	



1. Name of deceased: John Doe
 2. Sex: Male
 3. Date of birth: Jan 1, 1880
 4. Place of birth: Johns Hopkins
 5. Date of death: Dec 1, 1913
 6. Place of death: Johns Hopkins
 7. Cause of death: Heart Disease
 8. Duration of illness: 10 days
 9. Name of physician: Dr. J. H. Smith
 10. Name of undertaker: Johns Hopkins
 11. Name of informant: John Doe
 12. Address of informant: Johns Hopkins
 13. Signature of informant: [Signature]
 14. Signature of physician: [Signature]
 15. Date of certificate: Dec 1, 1913
 16. Place of certificate: Johns Hopkins

1

12172

12126

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b 2 yr.-4 mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 913 - 5th Street S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Ezell Last Johnson		4. DATE OF DEATH Month November Day 2 Year 1960	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/42
9. AGE (In years last birthday) 18 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 18 Days 18 Hours 18 Min. 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Newell Johnson		14. MOTHER'S MAIDEN NAME Mary Alice Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Children's Center, Laurel, Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia (repeated episodes) DUE TO 325.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spastic quadriplegia DUE TO (c) Mental retardation		INTERVAL BETWEEN ONSET AND DEATH 2 yr. 4 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Convulsive disorder			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour o. m. -- p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --	20f. (City or town) -- (County) -- (State) --
21. I certify that I attended the deceased from June 6, 1958 to Nov. 2, 1960 , that I last saw the deceased alive on Nov. 2, 1960 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. Boyland		ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. 11/2/60	
PHYSICIAN'S NAME (Type) James E. Boyland, M.D.		DATE SIGNED 11/2/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/8/60	22b. DATE THEREOF 11/8/60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) Arlington (State) VA
23. FUNERAL DIRECTOR'S SIGNATURE Hoffman Funeral Home		24a. REC'D BY REGISTRAR NOV 7 '60	
ADDRESS 909-6 St. N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12172

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Date of death: <u>12/15/1917</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Cause of death: <u>Heart Disease</u></p>	
<p>5. Age at death: <u>65</u></p>	
<p>6. Sex: <u>Male</u></p>	
<p>7. Race: <u>White</u></p>	
<p>8. Occupation: <u>Farmer</u></p>	
<p>9. Signature of physician: <u>Dr. J. H. Smith</u></p>	
<p>10. Signature of registrar: <u>W. H. Jones</u></p>	

12137

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence CRAIN Hopkins Jones		4. DATE OF DEATH Month Day Year Nov. 16 1960	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14 - 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) A.A.CO. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sam Jones		14. MOTHER'S MAIDEN NAME Isabel Hillary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Annie Thomas-104 Clay St. Annapolis-Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure due to Arteriosclerotic Hypertensive Cardio Vascular disease and grade III DUE TO (b) to Arteriosclerotic Hypertensive Cardio DUE TO (c) Vas embol disease and grade III PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 8/15/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/15/60 to Nov 17, 1960 , that I last saw the deceased alive on Nov 17, 1960 , and that death occurred at 11:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE R.L. Richardson M.D.		M.D.	
PHYSICIAN'S NAME (Type) R.L. Richardson M.D.		110 Clay Street Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-19-60	22c. NAME OF CEMETERY OR CREMATORY Brewer Hill	22d. LOCATION (City, town, or county) (State) Annapolis-Md.
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks		24a. REC'D BY REGISTRAR DATE NOV 23 '60	
ADDRESS ANNAPODIS-MD		24b. REGISTRAR'S SIGNATURE C. E. Hicks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

February 1992

for the 1990-1991 season.

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1994

bioRxiv preprint doi: <https://doi.org/10.1101/000000>; this version posted April 1, 2015. The copyright holder for this preprint (which was not certified by peer review) is the author/funder, who has granted bioRxiv a license to display the preprint in perpetuity. It is made available under aCC-BY-NC-ND 4.0 International license.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G276 12-14-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12139

12128

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville (Elvaton Acres)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First KATHRYN Middle KATLIC Last KATLIC			4. DATE OF DEATH Month NOV. Day 10 Year 1960		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 July 1910		9. AGE (In years lost birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Louisville Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME (unknown) Lacefield			14. MOTHER'S MAIDEN NAME (unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-28-2148		INFORMANT Mr. Charles Katlic Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 410x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease DUE TO (c) with mitral stenosis.					INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Sept 4 , 19 60 to Nov. 10 , 19 60 , that I last saw the deceased alive on Nov. 10 , 19 60 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Edmond I. Moushabeck		ADDRESS (Street, city or town, state) 2101 S. Ritchie Highway		DATE SIGNED 11/10/60	
PHYSICIAN'S NAME (Type) EDMOND I. MOUSHABEK		Glen Burnie, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 15th Nov. 1960	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard T. Singleton		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE NOV 14 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

BP

10-7-1964 19-12-63

12138

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle KENNEDY Last				4. DATE OF DEATH Month 11-27 Day 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-60		9. AGE (In years last birthday) -- yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 23 Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Robert KENNEDY				14. MOTHER'S MAIDEN NAME Marion Bernice WOISKONT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT (F) John Robert KENNEDY, 6 Alder Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress Syndrome 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH ---
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour 19 o. m. --- p. m. ---	Month, Day, Year 11-27-60	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8:20 PM 11-26-60 to 8:10 PM 11-27-60 , that I last saw the deceased alive on 11-27-60 , and that death occurred at 8:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John J. Mc Cann				ADDRESS (Street, city or town, state) --- DATE SIGNED 11-28-60			
PHYSICIAN'S NAME (Type) J. J. MC CANN, LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-29-1960	22c. NAME OF CEMETERY OR CREMATORY Naval Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis Md			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Scyler - San Annapolis Md				24a. REC'D BY REGISTRAR NOV 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

2051222XVI

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		DATE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]		SURVIVAL [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF JUDGE [Illegible]	

CHIEF CLERK
 BALTIMORE, MD

12173

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u>		b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		d. STREET ADDRESS <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 492 A</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marvince Kess</u>		First Middle Last		4. DATE OF DEATH <u>November 24th. 1960</u>		Month Day Year	
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/5/60</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>19</u> Days		IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raymond Kess</u>		14. MOTHER'S MAIDEN NAME <u>Evelynn Kane</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>		17. INFORMANT <u>Evelynn Kane (mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Infection</u> <u>527-2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>Gustave H. Paubert</u>		M.D.		DATE SIGNED <u>11/24/60</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Paubert, M.D.</u>		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>10/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Church</u>		22d. LOCATION (City, town, or country) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR <u>Marshall P. Allen</u>		ADDRESS <u>638 N. 9th St. Baltimore</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Received of Mr. J. W. Jones \$100.00
for the purchase of the land

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12131

12174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H.H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 27</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Baltimore 27</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3325 Hollins Ferry Rd.</u>		d. STREET ADDRESS <u>13375 Hollins Ferry Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Belle</u> Last <u>Minster</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-88</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>Walter Sykes</u>		14. MOTHER'S MAIDEN NAME <u>BELTHA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Family - Same</u>	
17. INFORMANT <u>Family - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>731X</u> DUE TO <u>Podgys Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>731X</u> DUE TO <u>Podgys Disease</u> (c) <u>731X</u> DUE TO <u>Podgys Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 16, 1955</u> to <u>Nov 28, 1960</u> that I last saw the deceased alive on <u>Nov 27, 1960</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Schmfield</u>		ADDRESS (Street, city or town, state) <u>2301 Annapolis Rd Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>PAUL Schmfield</u>		DATE SIGNED <u>11/29/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/1/60</u>		22b. DATE THEREOF <u>12/1/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowlands</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClary-130 E. Fort Ave.</u>		ADDRESS <u>McClary-130 E. Fort Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Pinaud</u>	

12140

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12132

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joanna Middle Mary Last KNIPP		4. DATE OF DEATH Month November Day 10 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1960
9. AGE (In years last birthday) 4		10. IF UNDER 1 YEAR Months 4 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stephen Shepard KNIPP		14. MOTHER'S MAIDEN NAME Marion Elizabeth HAZEBROEK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diaphragmatic Hernia lpr - Congenital 560.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypoplasia - lpr lung - congenital DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from Nov. 9, 1960 to Nov. 9, 1960 , that (I) was last saw the deceased alive on Nov. 9, 1960 , and that death occurred at 1:40 A.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Philip Briscoe		22b. ADDRESS 95 Cathedral St., Annapolis, Md.	
22c. PHYSICIAN'S NAME (Type) Philip Briscoe		22d. ADDRESS 95 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 12-1960	
23c. NAME OF CEMETERY OR CREMATORY St Marys Cem		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		25a. REC'D BY REGISTRAR DATE NOV 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur D. Thomas		25c. REGISTRAR'S NAME Arthur D. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12132

12140

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

1

11/10/00

11/10/00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12175

CERTIFICATE OF DEATH

12133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>				c. LENGTH OF STAY IN 1b <u>2 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BUENA VISTA, ARNOLD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>S.</u> Last <u>LAWRENCE</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 5, 1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Derrenberger</u>				14. MOTHER'S MAIDEN NAME <u>Anna Herbst</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. John C. Derrenberger, BUENA VISTA AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE—20 YEARS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>4 HOUR</u> <u>5 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-1</u> 19 <u>60</u> , to <u>11-8</u> 19 <u>60</u> , that I last saw the deceased alive on <u>11-8</u> 19 <u>60</u> , and that death occurred at <u>8:15 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>RITCHIE HIGHWAY SEVERNA PARK</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>J. D. Yun</u>				M.D. <u>RITCHIE HIGHWAY SEVERNA PARK</u>			
PHYSICIAN'S NAME (Type) <u>J. D. YUN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tichenor</u> ADDRESS <u>Baltimore 17, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1913

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

CERTIFICATE OF DEATH

1913

DATE OF DEATH

DECEASED

SEX

AGE

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DECEASED

SEX

AGE

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12134

12141

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. STREET ADDRESS Rt. 2, Box 26	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leo Middle E. Last LeBel		4. DATE OF DEATH Month November Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 May 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Post Ord. FT. Meade	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 225-22-4017	
17. INFORMANT Mrs. Omer Butler		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding esophageal Varices DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cirrhosis of Liver DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 8 hr. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-16-1960 to 11-18-1960 , that (I) (we) last saw the deceased alive on 11-18-1960 , and that death occurred at 5 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 11/18/60	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-22-60	
23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore City Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert P. Ware ADDRESS Home		25a. REC'D BY REGISTRAR DATE NOV 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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12141

James Arnold

Harvard

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James Arnold

Annals

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James Arnold General Hospital

No. 2, Box 26

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November 18

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Male White

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.
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12176
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13219

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Riva c. LENGTH OF STAY IN 1b Rural Edgewater d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Riva		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Edgewater d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KENNETH LEE W. First Middle Last 4. DATE OF DEATH November 27 1960 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH OCT 25 1922 9. AGE (In years last birthday) 38 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE REPAIRMAN 10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME STEPHEN LEE 14. MOTHER'S MAIDEN NAME JULIA MEADE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WWII 16. SOCIAL SECURITY NO. WW II 17. INFORMANT JOSEPH LEE #2 Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries 866X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Crash 20c. TIME OF INJURY Month, Day, Year 1:00 Nov. 27 1960 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) field 20f. (City or town) (County) (State) Riva Anne Arundel Maryland		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/27/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 11-30-1960 22c. NAME OF CEMETERY OR CREMATORY US NATIONAL CEM 22d. LOCATION (City, town, or country) (State) ANNAPOLIS MD		23. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD ADDRESS ANNAPOLIS MD 24a. REC'D BY REGISTRAR NOV 29 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
12142
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12135

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital		d. STREET ADDRESS 711 Arundel Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marie First R. Middle LEE Last		4. DATE OF DEATH November Month 6 Day 1960 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1893
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs Violet Austin Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4 43X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) 5 YRS		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) did not attended the deceased from 6 OCT 1960 to 6 NOV 1960 , that (I) did not saw the deceased alive on 21 OCT 1960 , and that death occurred at 6:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 11/7/60	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 71 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-9-1960	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemt		23d. LOCATION (City, town, or county) (State) Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sene		25a. REC'D BY REGISTRAR NOV 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. K...			

18142

CERTIFICATE OF DEATH

Name of deceased

Name of deceased

Age of deceased

Age of deceased

Place of death

Place of death

Sex

Sex

Cause of death

Cause of death

18142

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12136

12177

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. LENGTH OF STAY IN 1b Elkridge 27			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort George G. Meade				d. STREET ADDRESS 13X-2			
3. NAME OF DECEASED (Type or print) First MICHAEL Middle W. Last LIPSTER				4. DATE OF DEATH Month Nov. Day 5 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1960	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 2		IF UNDER 24 HRS. Hours 1 Min. 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Fort George G. Meade Hos.	
12. CITIZEN OF WHAT COUNTRY? None				13. FATHER'S NAME Roger A. Lipster			
14. MOTHER'S MAIDEN NAME Marilyn A. Mills				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Alladin Traller Village Roger A. Lipster, Elkridge 27, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Interstitial Pneumonitis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 492X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W. Bradley King, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				DATE SIGNED 11/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-60		22c. NAME OF CEMETERY OR CREMATORY Markelie		22d. LOCATION (City, town, or county) (State) Hudson, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR NOV 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2050222XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 10
15M 9/59

12178

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12134

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U.S.A.H.		c. LENGTH OF STAY IN H. 5 hrs 25 Min	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS 507 Main St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fort George G. Meade, Mar land		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kevin Michael Middle Lutz Last Lutz		4. DATE OF DEATH Month November Day 19 Year 1960	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-19-60
9. AGE (In years lost birthday) yrs. 5		IF UNDER 1 YEAR Months 5 Days 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL J LUTZ		14. MOTHER'S MAIDEN NAME BARBARA BROWER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT Father		Address 507 Main St Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Atelectesis in Newborn Infant 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 hrs 25 Min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 Nov 1960 to 19 Nov 1960 that (I) (we) last saw the deceased alive on 19 Nov 1960 , and that death occurred at 7:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Sherman S. Robinson		22b. DATE SIGNED 19 Nov 60	
22c. PHYSICIAN'S NAME (Type) SHERMAN S. ROBINSON		22d. ADDRESS USA Hosp Ft Geo G. Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/22/60	
23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Middle Village, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE De Witt Canalehan, Laurel Md		25a. REC'D BY REGISTRAR NOV 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hana			

2050222XV4

15178

CENTRAL OF DEATH

DEPARTMENT OF HEALTH

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12143

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8 & 9, Film G-278 1/11/61.cac

12138

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 46 Murray Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Margaret		Middle B		Last MACE		4. DATE OF DEATH Month November		Day 30		Year 1960		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1886 March 11, 1883		9. AGE (In years last birthday) 74 77 yrs.		10. IF UNDER 1 YEAR Months 74		11. IF UNDER 24 HRS. Days 77		Hours 77		Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME HENRY EDLING		14. MOTHER'S MAIDEN NAME GEORGE MARY HAHN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT GEORGE E. MACE		Address (2)											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, generalized DUE TO Perforation of sigmoid colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Valvular disease of sigmoid colon (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (the hospital) attended the deceased from Nov. 25, 1960 to Nov. 30, 1960 , that (I) (we) last saw the deceased alive on Nov. 30, 1960 , and that death occurred at 6:30 P.M. M, from the causes and on the date stated above.		22a. SIGNATURE Jesse L. Wilkins		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/1/60		22c. PHYSICIAN'S NAME (Type) Jesse L. Wilkins M.D.		22d. ADDRESS 100 Cathedral St., Annapolis, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 3-1960		23c. NAME OF CEMETERY OR CREMATORY St Armes Cemetery		23d. LOCATION (City, town, or county) Annapolis Md.											
24. FUNERAL DIRECTOR'S SIGNATURE John M. Seaylor Sons		ADDRESS Annapolis Md.		25a. REC'D BY REGISTRAR DATE DEC 5 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hesse																							

15143

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

15143

1. Name of the plant: *...*

2. Name of the collector: *...*

3. Locality: *...*

4. Date of collection: *...*

5. Number of specimens: *...*

6. Description of the plant: *...*

7. Remarks: *...*

8. Name of the collector: *...*

9. Name of the collector: *...*

10. Name of the collector: *...*

11. Name of the collector: *...*

12. Name of the collector: *...*

13. Name of the collector: *...*

14. Name of the collector: *...*

15. Name of the collector: *...*

16. Name of the collector: *...*

17. Name of the collector: *...*

18. Name of the collector: *...*

19. Name of the collector: *...*

20. Name of the collector: *...*

21. Name of the collector: *...*

22. Name of the collector: *...*

23. Name of the collector: *...*

24. Name of the collector: *...*

25. Name of the collector: *...*

26. Name of the collector: *...*

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35. Name of the collector: *...*

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39. Name of the collector: *...*

40. Name of the collector: *...*

41. Name of the collector: *...*

42. Name of the collector: *...*

43. Name of the collector: *...*

44. Name of the collector: *...*

45. Name of the collector: *...*

46. Name of the collector: *...*

47. Name of the collector: *...*

48. Name of the collector: *...*

49. Name of the collector: *...*

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81. Name of the collector: *...*

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91. Name of the collector: *...*

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95. Name of the collector: *...*

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97. Name of the collector: *...*

98. Name of the collector: *...*

99. Name of the collector: *...*

100. Name of the collector: *...*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

CENTRAL STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12179 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12139

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN TB 14 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		d. STREET ADDRESS Route #5, Magothy Beach			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #5, Magothy Beach				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DOROTHY M McClain				4. DATE OF DEATH Month November Day 27 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/13/1925			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. Mr James A. McClain		17. INFORMANT Magothy Beach			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of upper abdomen and lower chest DUE TO (b) 9 8 1 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation					
20c. TIME OF INJURY Month, Day, Year 7:10 p.m. 11/27/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House		20f. (City or town) (County) (State) Pasadena, Anne Arundel, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE R S Fisher				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/1/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem			
23. FUNERAL DIRECTOR John J. Cowan & Son				ADDRESS 29 Hollins St.		24a. REC'D BY REGISTRAR NOV 30 '60			
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

18130

18130

WESTERN MEDICAL DEPARTMENT OF CALIFORNIA
MEDICAL DEPARTMENT OF CALIFORNIA
MEDICAL DEPARTMENT OF CALIFORNIA

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE: [illegible]
PLACE: [illegible]

REASON FOR CONSULTATION: [illegible]
HISTORY: [illegible]
PHYSICAL EXAMINATION: [illegible]

LABORATORY EXAMINATIONS: [illegible]
DIAGNOSIS: [illegible]
TREATMENT: [illegible]

PROGNOSIS: [illegible]
FOLLOW-UP: [illegible]

REMARKS: [illegible]

SIGNATURE: [illegible]
DATE: [illegible]

18130

CERTIFICATE OF DEATH

Reg. Dist. No.

12180

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, RFD</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lude Drive, Lake Shore</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, (Lake Shore)</u>			
				d. STREET ADDRESS <u>Rt. 7 - Box 24A</u>			
				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RAY HOWARD MELLOTT</u>				4. DATE OF DEATH <u>November 5, 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2nd May 1903</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John G. Mellott</u>				14. MOTHER'S MAIDEN NAME <u>Alice Bedford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>183 12 3953</u>		17. INFORMANT <u>Mrs. Margaret Stinchcomb</u>		Address <u>Kent Ave., Pasadena, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHO-PNEUMONIA</u> <u>292.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>APLASTIC ANEMIA</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>3 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CACHEXIA</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>AUG 22, 1960</u> , to <u>NOV 4, 1960</u> , that I last saw the deceased alive on <u>OCTOBER 25, 1960</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>				M.D. <u>2934 MOUNTAIN RD.</u>		DATE SIGNED <u>11-7-60</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>				<u>PASADENA MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8th Nov. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. V. Brighton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12141

12181

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chaptico			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ella		First Counters		Last Miles		4. DATE OF DEATH Month 11 Day 3 Year 19 60	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 19, 1888	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Counters				14. MOTHER'S MAIDEN NAME Julia Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 11/3 5:58 to 11/3 19 60 , that (I) (we) last saw the deceased alive on 11/3 19 60 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict, M. D.				22b. DATE 11/4/60			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/8/60		23c. NAME OF CEMETERY OR CREMATORY St Joseph		23d. LOCATION (City, town, or county) (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE McCluskey				25a. REC'D BY REGISTRAR Nov 9 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

1511

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

15181

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
AGE
SEX
MARRIAGE
OCCUPATION
CAUSE OF DEATH
PLACE OF BIRTH
DATE OF BIRTH
MOTHER'S NAME
FATHER'S NAME
REGISTRATION
CERTIFICATE OF DEATH

1511

Handwritten signature

Registrar of Vital Records

State of Massachusetts

12144
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXX Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Hosp. Annapolis, Md.				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Mae Middle A. Last Miller				4. DATE OF DEATH Month November Day 30 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8- 1890	
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Paul L. Miller				Address Shady Side, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage 959X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dicumerol poisoning DUE TO (c) Probably therapeutic misadventure; patient had been taking dicumerol for 3 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) EKG. shows patient also had a recent acute myocardial infarction.							
INTERVAL BETWEEN ONSET AND DEATH 24 hours same							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Shady Side, Maryland				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov. 29, 1960 to Nov. 30, 1960 that I last saw the deceased alive on Nov. 30, 1960 , and that death occurred at 7:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard F. Smith				DATE SIGNED 11/30/60			
PHYSICIAN'S NAME (Type) WILLARD F. SMITH, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 3- 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Suitland, Maryland.				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Samuel Brokers				ADDRESS 1661- Good Hope Rd. S.E. Washington, DC		24a. REC'D BY REGISTRAR DATE DEC 2 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any way is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
12143									
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Riva					c. LENGTH OF STAY IN lb rural Woodland Beach				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Riva					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM E. MILLER					4. DATE OF DEATH Month November Day 27 Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 8, 1916		9. AGE (In years last birthday) 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REALTOR		10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) ANNAPOLIS MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ERNEST MILLER					14. MOTHER'S MAIDEN NAME IDA ISABELLE SWEETING				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes WWII					16. SOCIAL SECURITY NO. WW II				
17. INFORMANT SHIRLEY M. MILLER #2					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries 866X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. TIME OF INJURY Month, Day, Year Hour a.m. 1:00 Nov. 27 1960					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Crash				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:00 Nov. 27 1960					20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) field				
20e. (City or town) Riva					20f. (County) Anne Arundel				
20g. (State) Maryland									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Petty					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Charles S. Petty					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					Address (Street, city, town, or county) 11/27/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-30-1960		22c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF CEM.		22d. LOCATION (City, town, or country) (State) ANNAPOLIS MD.			
23. FUNERAL DIRECTOR JOHN M. TAYLOR					24a. REC'D BY REGISTRAR NOV 29 '60				
ADDRESS SOUS ANNAPOLIS MD.					24b. REGISTRAR'S SIGNATURE Arthur S. Hous				

12143

12182

FOR THE
RECORD

James Randall

Harvard

James Randall

Woodward Parish

Parish

Five

November 27

12182

Male

White

1

Multiple traumatic injuries

Alcoholic Intoxication

James Randall

Male

12182

x

x

x

12182

There is no

12182

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12144

12183

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 3 1/4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				d. STREET ADDRESS 72 1/2 Larkins St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Jane Mowbray				4. DATE OF DEATH Month November 2, Day 19 Year 60			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-20-1870		9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Welch				14. MOTHER'S MAIDEN NAME Catherine Tydings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address M. Anderson -Worker, D.P.W. A.A. Co.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ? yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 9, 1957 to Nov. 2, 1960 , that (I) (we) last saw the deceased alive on Oct. 15, 1960 , and that death occurred at 8A M, from the causes and on the date stated above.							
22a. SIGNATURE James M. Pair				22b. DATE SIGNED Nov. 2, 1960		22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.	
22d. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802 Madison Avenue		25a. REC'D BY REGISTRAR DATE NOV 4 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

BP

CRIST

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H. H. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sanns Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>F.</u> Last <u>MYERS</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>V-PRES.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARDWARE STORE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY B. MYERS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HENKEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>H. FENTON MYERS</u>		17. INFORMANT <u># 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>7 wks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>Sept 23</u> , 19 <u>60</u> , to <u>Nov 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>60</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Edwards</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u>		DATE SIGNED <u>11/9/60</u>	
PHYSICIAN'S NAME (Type) <u>John M. Edwards</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-11-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EDWARDS CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Edwards</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Edward S. [illegible]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12184

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES M. SMITH		Male		45		1880		New York		Clerk		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE		14. PRESENT ILLNESS		15. MEDICAL HISTORY		16. SIGNATURE OF PHYSICIAN	
1880		10:00 AM		Home		Heart Disease		Coronary Artery Sclerosis		Myocardial Infarction		Hypertension		J. M. Smith, M.D.	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF CLERGYMAN		22. SIGNATURE OF BURIAL OFFICIAL		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CEMETERY	
A. B. Smith		C. D. Jones		D. E. Brown		F. G. White		H. I. Black		J. K. Green		L. M. Blue		N. O. Yellow	

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND CORRECT. ANY FALSIFICATION OF THIS CERTIFICATE IS A CRIME UNDER THE LAWS OF THE STATE OF MARYLAND.

54151

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12185

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12147

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD ✓		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Riva			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood 12X-2		
c. LENGTH OF STAY IN Ib aprox 2 1/2 yrs			d. STREET ADDRESS Army Chemical Center		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Riva					
3. NAME OF DECEASED (Type or print) Charles W. Player			4. DATE OF DEATH Nov. 27 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1935		9. AGE (In years last birthday) 25 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Chemical Center U.S Army		10b. KIND OF BUSINESS OR INDUSTRY U.S Army		11. BIRTHPLACE (State or foreign country) Feb. 3, 1935	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Unknown - deceased		
14. MOTHER'S MAIDEN NAME deceased - unknown			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes Now Active Unknown		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Ft. Holibird Service Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 866X DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Crash		
20c. TIME OF INJURY Month, Day, Year 1:00 Nov. 27 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) field	
20f. (City or town) Riva		20g. (County) Anne Arundel		20h. (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Charles S. Petty			Address (Street, city, town, or county) 11/27/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/30/60		22c. NAME OF CEMETERY OR CREMATORY J.T. Morriss + Son Inc Petersburg, Virginia	
23. FUNERAL DIRECTOR B. Wolverton 6306 - Belair Rd, Baltimore - 6, Md.			24a. REC'D BY REGISTRAR DEC 1 '60		
24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

MEDICAL CERTIFICATION

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multiple transmittal

Distance Graph

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12146 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 Northwest Street				d. STREET ADDRESS 99 Northwest Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Evan Pointer (Bobby)				4. DATE OF DEATH Month November Day 27 Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25-1907	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Utilities U.S. Naval Exp. Station		10b. KIND OF BUSINESS OR INDUSTRY Annapolis		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Pointer				14. MOTHER'S MAIDEN NAME Agnes Hawkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Velma B. Nash-808 Carrollton Ave. Anna. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. L. W. HARRIS				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/27/60	
EXAMINER'S NAME (Type) E. L. W. HARRIS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-60		22c. NAME OF CEMETERY OR CREMATORY Pine Lawn		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE DEC 1 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. Hous			

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1150

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12149

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION, (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>15 Parkley Road.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>John William Popow</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1960</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>									
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 10th 1914</u>		9. AGE (In years last birthday) <u>46</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prof at U.S. NAVAL ACADEMY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEACHER</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George Popow</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Bohm</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W. II</u>		16. SOCIAL SECURITY NO. <u>12-1-1960</u>		17. INFORMANT <u>Helen Christine Popow</u> Address <u>(2)</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> 43 4.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. </td> <td> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </td> </tr> <tr> <td colspan="2"> DUE TO (b) DUE TO (c) </td> <td></td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> 43 4.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	DUE TO (b) DUE TO (c)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> 43 4.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
DUE TO (b) DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/28/60</u>									
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>12-1-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12117

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
12117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Examiner	
9. Signature of Physician		10. Signature of Coroner		11. Signature of Medical Examiner		12. Signature of Registrar	
13. Signature of Undertaker		14. Signature of Burial Place		15. Signature of Funeral Home		16. Signature of Cemetery	
17. Signature of Mortician		18. Signature of Embalmer		19. Signature of Preparer		20. Signature of Burial Place	
21. Signature of Funeral Home		22. Signature of Cemetery		23. Signature of Mortician		24. Signature of Embalmer	
25. Signature of Preparer		26. Signature of Burial Place		27. Signature of Funeral Home		28. Signature of Cemetery	
29. Signature of Mortician		30. Signature of Embalmer		31. Signature of Preparer		32. Signature of Burial Place	
33. Signature of Funeral Home		34. Signature of Cemetery		35. Signature of Mortician		36. Signature of Embalmer	
37. Signature of Preparer		38. Signature of Burial Place		39. Signature of Funeral Home		40. Signature of Cemetery	
41. Signature of Mortician		42. Signature of Embalmer		43. Signature of Preparer		44. Signature of Burial Place	
45. Signature of Funeral Home		46. Signature of Cemetery		47. Signature of Mortician		48. Signature of Embalmer	
49. Signature of Preparer		50. Signature of Burial Place		51. Signature of Funeral Home		52. Signature of Cemetery	
53. Signature of Mortician		54. Signature of Embalmer		55. Signature of Preparer		56. Signature of Burial Place	
57. Signature of Funeral Home		58. Signature of Cemetery		59. Signature of Mortician		60. Signature of Embalmer	
61. Signature of Preparer		62. Signature of Burial Place		63. Signature of Funeral Home		64. Signature of Cemetery	
65. Signature of Mortician		66. Signature of Embalmer		67. Signature of Preparer		68. Signature of Burial Place	
69. Signature of Funeral Home		70. Signature of Cemetery		71. Signature of Mortician		72. Signature of Embalmer	
73. Signature of Preparer		74. Signature of Burial Place		75. Signature of Funeral Home		76. Signature of Cemetery	
77. Signature of Mortician		78. Signature of Embalmer		79. Signature of Preparer		80. Signature of Burial Place	
81. Signature of Funeral Home		82. Signature of Cemetery		83. Signature of Mortician		84. Signature of Embalmer	
85. Signature of Preparer		86. Signature of Burial Place		87. Signature of Funeral Home		88. Signature of Cemetery	
89. Signature of Mortician		90. Signature of Embalmer		91. Signature of Preparer		92. Signature of Burial Place	
93. Signature of Funeral Home		94. Signature of Cemetery		95. Signature of Mortician		96. Signature of Embalmer	
97. Signature of Preparer		98. Signature of Burial Place		99. Signature of Funeral Home		100. Signature of Cemetery	

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12150

12186 CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md</u> COUNTY <u>AA</u>		CITY (If outside corporate limits, write RURAL or and give nearest town) <u>GLEN BURNIE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 Wilson Blvd.</u>		STREET ADDRESS (If rural give location) <u>19 Wilson Blvd.</u>		CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Glen Burnie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
3. NAME OF DECEASED (Type or Print) <u>Mc Rina Estelle POWELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 5 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>Oct 9, 1871</u>	
9. AGE last birthday <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Ashburn</u>		14. MOTHER'S MAIDEN NAME <u>MARY Ashburn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>MARY POWELL, same as 2</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>		ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>Oct 25, 1960</u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Oct 25, 1960</u> , to <u>Nov 5, 1960</u> , that I last saw the deceased alive on <u>Oct 25, 1960</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.		23. BURLIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	
24. REC'D BY REGISTRAR <u>NOV 9 '60</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping + KIRKLEY</u>		26. DATE <u>NOV 9 '60</u>		27. ADDRESS (Street, city, town, state) <u>102 B & A Blvd. N.E. Glen Burnie, Md</u>	
28. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>		29. NAME OF CEMETERY OR CREMATORY <u>Roseland Cemetery</u>		30. LOCATION (City, town, or county) <u>Kilmarnock, VA.</u>		31. DATE SIGNED <u>Nov 5, 1960</u>	

12187

CERTIFICATE OF DEATH

12151

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Welcome, Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Welcome, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>1 year 4 mo, 15 days</u>				d. STREET ADDRESS <u>08X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Sherman</u> Last <u>Proctor</u>				4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/1934</u>		9. AGE (In years lost birthday) yrs. <u>26</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>USA, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Jane Proctor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition and Dehydration</u> <u>722.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ankylosing Rheumatoid Arthritis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/26</u> , 19 <u>59</u> , to <u>11/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/10</u> , 19 <u>60</u> , and that death occurred at <u>10</u> a.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Enrique J. del Campo</u> M.D.				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>		DATE SIGNED <u>11-11-60</u>	
PHYSICIAN'S NAME (Type) <u>Enrique J. del Campo</u>				<u>Crownsville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/14/60</u>		<u>Zion Baptist</u>		<u>Will Top, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archib. Funeral Home, LaPlata, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12148

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12152

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>35 Cathedral St.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>35 Cathedral St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Georgeana</u> Middle <u>Rawlings</u> Last <u>Rawlings</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1909</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	11. IF UNDER 24 HRS. Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William McKinley Hosting</u>		14. MOTHER'S MAIDEN NAME <u>Georgeana Lavel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>170</u>	
17. INFORMANT <u>Sewell Rawlings</u>		Address <u>35 Cathedral St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO <u>metastases to various organs</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>about 6 mos</u> DUE TO (c) <u>about 6 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>170X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1960</u> to <u>10-31-60</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>10-30-60</u> 19 <u>60</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>G. T. Allen</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>G. T. ALLEN</u>		22d. ADDRESS <u>35 Cathedral St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-4-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>		23d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Harris</u>	
ADDRESS <u>Annapolis</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	
DATE <u>NOV 7 '60</u>			

15148

CERTIFICATE OF ENTRY

15148

CHIEF OF BUREAU

DEPARTMENT OF

IMMIGRATION

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

12149

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12153

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>78 College Ct Terrace</i>		d. STREET ADDRESS <i>78 College Ct Terrace</i>	
3. NAME OF DECEASED (Type or print) <i>Mary E. Reed</i>		4. DATE OF DEATH <i>11-7-1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-5-1898</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lewis Mathews</i>		14. MOTHER'S MAIDEN NAME <i>Susie Gross</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>	
17. INFORMANT <i>Thomas Mathews</i>		Address <i>78 College Ct Terrace</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>metastasis to vital organs</i> 174X DUE TO <i>Carcinoma / uterus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>(c)</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>(b) (c)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>about 4 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Annapolis a.g.</i>		20f. (City or town) (County) (State) <i>Ind</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1-6-56</i> to <i>11-7-60</i> , that (I) (we) last saw the deceased alive on <i>11-6-60</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Aris T. Allen</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>ARIS T ALLEN</i>		22d. ADDRESS <i>62 Cothran St</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-10-1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Beverly Hill</i>		23d. LOCATION (City, town, or country) (State) <i>Annapolis Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		25a. REC'D BY REGISTRAR <i>Nov 9 1960</i>	
ADDRESS <i>Annapolis Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Thomas</i>	

13143

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA
IN RE: THE ESTATE OF
CERTIFICATE OF DEATH

13143



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12150

CERTIFICATE OF DEATH

12154

Item 8 Film 62/6 12-5-60 et

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Will</u> Middle <u>Robinson</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1902</u> <u>4-21-1902</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Orangeburg S. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>704-14-8604</u>	
17. INFORMANT <u>Rev. J. Carroll</u>		Address <u>Crownsville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrolytic Intoxication</u> DUE TO <u>Vomiting & Diarrhea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cause undetermined</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11-25-60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-25-60</u> to <u>11-26-60</u> that (I) (we) last saw the deceased alive on <u>November 26, 1960</u> and that death occurred at <u>8:35 A.M.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Ar. T. Allen</u>		22b. DATE SIGNED <u>8:35 A.M.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Aris T. Allen</u>		22d. ADDRESS <u>Cathedral Street</u> <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>		23b. DATE THEREOF <u>Nov. 26, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel</u>		23d. LOCATION (City, town, or county) (State) <u>Branchville S. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1960</u>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

13131

CERTIFICATE OF DEATH

13130

Name of deceased

Age

Sex

Marital status

Occupation

Place of birth

60

55

November

1900

1911

Male

Single

1

CHILLICOTHE

0132 A.M.

November 25, 1900

Annals, Mo.

Annals, Mo.

Dr. A. T. Allen

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12155

12188

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>X</i> b. COUNTY <i>Advent</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Linthicum</i>				c. LENGTH OF STAY IN 1b <i>4 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>606 N. Harmondale Ferry Rd - 1</i>				d. STREET ADDRESS <i>Advent</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Martin George Schurfer</i>				4. DATE OF DEATH Month Day Year <i>Nov 5 1960</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>Sept 9, 1889</i>	
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Turnston Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Antigua</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>George Schurfer</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Herbert</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-05548</i>		17. INFORMANT Address <i>Christine Eichelman (Sister) (Same)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Vascular Disease</i> 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchial Asthma</i> DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Jan 16, 1959</i> to <i>Nov 5, 1960</i> , that I last saw the deceased alive on <i>Nov 5, 1960</i> , and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chas. L. Ball Jr.</i> M.D.				ADDRESS (Street, city or town, state) <i>Linthicum Md.</i> DATE SIGNED <i>11/5/60</i>			
PHYSICIAN'S NAME (Type) <i>Charles L. Ball, Jr.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>11-8-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Rd.</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 9 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton L. Kirsch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12151

12156

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lottie Middle SHERBERT Last SHERBERT		4. DATE OF DEATH Month November Day 14 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1881
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR: Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME STEPHEN Suite		14. MOTHER'S MAIDEN NAME Alma Suite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Men Alma Larimore	
17. INFORMANT Edgewater, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis generalizid DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocarditis (c) Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertrophosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (we) attended the deceased from Nov. 6, 19 60 , to Nov. 14, 19 60 , that (I) (we) last saw the deceased alive on Nov. 14, 19 60 , and that death occurred at 10:05 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Elmer G. Linhardt		22b. DATE SIGNED 11-14-60	
22c. PHYSICIAN'S NAME (Type) Elmer G. Linhardt		22d. ADDRESS 3 Chesapeake Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 17 1960	
23c. NAME OF CEMETERY OR CREMATORY Hope Chapel		23d. LOCATION (City, town, or county) (State) Edgewater Md	
24. FUNERAL DIRECTOR'S SIGNATURE T. A. Hardesty & Son		25a. REC'D BY REGISTRAR Galesville Md	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE NOV 21 '60	

15151

CERTIFICATE OF DEATH

15151

John A. Smith

John A. Smith

John A. Smith

1900-1901

1900-1901

1900-1901

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John A. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12152

12157

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Dean Street		d. STREET ADDRESS 5 Dean Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last SMITH		4. DATE OF DEATH Month November Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1867
9. AGE (In years lost birthday) 93 yrs.		IF UNDER 1 YEAR Months 1 Days 21 Hours 2 Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Armen		14. MOTHER'S MAIDEN NAME Frances McKelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.	
17. INFORMANT Mrs. Catherine Smith		Address 4604 Glenarm Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.00 Sept 6, 1960 DUE TO Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Renal insufficiency (c) 2 wks		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 6, 1960 to Nov 23, 1960 that (I) (we) last saw the deceased alive on Nov 18, 1960 , and that death occurred at 11:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE James R. Martin		22b. DATE SIGNED 11-23-60	
22c. PHYSICIAN'S NAME (Type) JAMES R. MARTIN		22d. ADDRESS 6 SHAW ST. ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/26/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, 4210 Belair Road.		25a. REC'D BY REGISTRAR NOV 28 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. House			

18152

18152

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Name of deceased		Sex		Age		Date of death	
John Doe		Male		35		Jan 15, 1915	
Place of birth		Occupation		Cause of death		Manner of death	
New York		Teacher		Heart disease		Natural	
Usual residence		Place of death		Physician		Hospital	
New York		New York		Dr. J. Smith		St. John's	
Signature of physician		Signature of registrar		Signature of witness		Signature of witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of registration		Place of registration		Signature of registrar		Signature of witness	
Jan 15, 1915		New York		[Signature]		[Signature]	

12154

CERTIFICATE OF DEATH

12154

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 21201
12189 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12159

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14 Brookfield Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Ellison Stallings Sr.</u>			4. DATE OF DEATH Month <u>November</u> Day <u>30th</u> Year <u>19 60</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/21</u>		9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pasadena Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Oliver Stallings</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Ellison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>216-18-5552</u>		17. INFORMANT <u>Mrs. Audrey Stallings</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Partial Decapitation, by shooting himself under chin</u> <u>976 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with a 12 gauge single barrell shot gun</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>As described in # 18</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>e.m.</u> <u>1:25 p.m.</u> <u>12/30/60</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pasadena Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12/2/60</u>			
				Address (Street, city, town, or county) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-3-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Magothy Church Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Pasadena Md.</u>	
23. FUNERAL DIRECTOR <u>Hopping & HARRIS, Glen Burnie</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

MEDICAL CERTIFICATION

121811
MAY 1941
OFFICE OF THE
ATTORNEY GENERAL
WASHINGTON, D. C.

RECEIVED
MAY 1941



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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12190

12160

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 4mo. 21 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville d. STREET ADDRESS Route 1, Box 52 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wilson		First James		Last Stewart		4. DATE OF DEATH Month 11 Day 28 Year 19 60	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1888	
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72		10. IF UNDER 24 HRS. Days 28 Hours 11 Min. 00		11. AGE (In years lost birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jacob Stewart			
14. MOTHER'S MAIDEN NAME Elizabeth ?				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown			
16. SOCIAL SECURITY NO. 214-30-5556				17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 7/7 2:40 to 11/28 19 60 , that (I) (we) last saw the deceased alive on 11/28 19 60 , and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict, M. D.				22b. DATE 11/29/60			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12-3-60				23b. DATE THEREOF 12-3-60		23c. NAME OF CEMETERY OR CREMATORY Davidsonville	
23d. LOCATION (City, town, or county) Davidsonville, Md.				23e. (State) Md.		23f. (Country) U.S.A.	
24. FUNERAL DIRECTOR'S SIGNATURE Funeral Home of Davidsonville				24b. ADDRESS Davidsonville		25a. REC'D BY REGISTRAR Arthur S. Harris	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris				25c. DATE DEC 2 '60		25d. (State) Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12191

CERTIFICATE OF DEATH

12161

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN ¹ mo 3yrs 29 days		d. STREET ADDRESS Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Last Stovall		4. DATE OF DEATH Month 11 Day 19 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1897
9. AGE (In years lost birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Georgia Samuels	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inhalation of Food causing Suffocation Asphyxia 921.7 DUE TO Choked Food in Pharynx and Larynx N/933 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Chronic Brain Syndrome Associated with Central Nervous System Syphilis		INTERVAL BETWEEN ONSET AND DEATH 1 min. / 1 Minute	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Central Nervous System Syphilis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Accidental death with inhaled egg white particles after breakfast. Medical Examiner notified, but did not accept case.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11 19 60 8 PM		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Crownsville A A Md.	
21. I certify that (I) (this hospital) attended the deceased from Sept. 20, 19 57 to Nov. 19 , 19 60 , that (I) (we) last saw the deceased alive on Nov. 19 , 19 60 , and that death occurred at 9.20 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 11/21/60 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11/26/60		23b. DATE THEREOF Nov. 26, 1960	
23c. NAME OF CEMETERY OR CREMATORY Int. Auburn Cemetery		23d. LOCATION (City, town, or county) (State) Crownsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE A. Halstead		ADDRESS 918 Druid Hill Ave	
25a. RECEIVED BY REGISTRAR 11/28/60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

Two for One: FilmG276 12-13-60 et

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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12192

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12162

1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>109 Maple Ave. Glen Burnie</u>		d. STREET ADDRESS <u>1109 Maple Ave. Glen Burnie</u>	
3. NAME OF DECEASED (Type or print) <u>Viola N. Suitt</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 12, 1924</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Simone</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Contenti</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>039-09-5341</u>	
17. INFORMANT <u>Edward C. Suitt</u>		18. ADDRESS <u>109 Maple Ave. Glen Burnie, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Metastases</u> DUE TO (c) <u>Adenocarcinoma Sigmoid Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u> <u>3 mos</u> <u>18 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>-</u> 19 <u>-</u> p. m. <u>-</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>7/10/1953</u> to <u>11/24</u> 19 <u>60</u> , that (I) (<u>we</u>) lost <u>11/23</u> 19 <u>60</u> , and that death occurred <u>6:15 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>R.W. Richard</u>		22b. DATE SIGNED <u>11/23</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.W. RICHARD</u>		22d. ADDRESS <u>715 Cottage Rd Glen Burnie, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem. Baltimore, Maryland</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		25a. REC'D BY REGISTRAR <u>NOV 28 '60</u>	
ADDRESS <u>4107 Wilkens Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

18105

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF BACTERIOLOGY
WASHINGTON, D. C.

18105

For the purpose of determining the
effect of the various factors on the
growth of the organism, the following
tests were made:

Test	Result
1. Growth on nutrient agar	Good
2. Growth on nutrient broth	Good
3. Growth on nutrient gelatin	Good
4. Growth on nutrient agar with 1% NaCl	Good
5. Growth on nutrient agar with 2% NaCl	Good
6. Growth on nutrient agar with 4% NaCl	Good
7. Growth on nutrient agar with 6% NaCl	Good
8. Growth on nutrient agar with 8% NaCl	Good
9. Growth on nutrient agar with 10% NaCl	Good
10. Growth on nutrient agar with 12% NaCl	Good

The results of the above tests show that the organism is capable of growing in the presence of up to 12% NaCl. This is a characteristic of halophilic organisms. The organism also grows on all the other media tested, indicating that it is a non-fastidious organism. The growth is best on nutrient agar and nutrient broth.

Prepared by: [Signature]
Checked by: [Signature]
Date: [Date]

12154

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12163

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle TATES Last TATES				4. DATE OF DEATH Month November Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1901		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) New Port News, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 DUE TO Coronary & Sui Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Atherosclerosis DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 4 min 30 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from Nov 15, 1960 to Nov. 15, 1960 , that (I) xx last saw the deceased alive on Nov. 15, 1960 , and that death occurred at 8:20 P.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Theodore H. Johnson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/16/60	
22c. PHYSICIAN'S NAME (Type) Theodore H. Johnson				22d. ADDRESS 37 Calvert St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-20-1960		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town, or country) (State) Annapolis, Md	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. Annap. Md.				25a. REC'D BY REGISTRAR NOV 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MASSACHUSETTS STATE ARCHIVES

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12164

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sara Middle THOMPSON Last THOMPSON				4. DATE OF DEATH Month November Day 9 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 1, 1905	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.		IF UNDER 24 HRS. Months 55 Days 55 Hours 55 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Duckett				14. MOTHER'S MAIDEN NAME Josephine Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Porter Thompson Churchton Md.			
17. INFORMANT Porter Thompson Churchton Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes				INTERVAL BETWEEN ONSET AND DEATH 6 days years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Nov. 4, 1960 to Nov. 8, 1960 , that (I) (we) last saw the deceased alive on Nov. 8, 1960 and that death occurred at 5:45 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Willard F. Smith				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/9/60	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith				22d. ADDRESS Shadyside, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-13-1960		23c. NAME OF CEMETERY OR CREMATORY St. Matthews		23d. LOCATION (City, town, or county) (State) Shadyside Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese # Anna Md.				25a. REC'D BY REGISTRAR NOV 10 '60		25b. REGISTRAR'S SIGNATURE Arthur J. Hanna	

CERTIFICATE OF DEATH

12185

Age at death

Sex

Place of birth

Married -

Occupation

Signature

Place of death

Time of death

Place of death

Signature

Age

Sex

Place of birth

Occupation

Signature



Signature

Signature

Age

Sex

Place of birth

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

12193

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12165

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 4 years 6mo. 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2533 Woodbrook Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Lula Middle Torrence Last Torrence				4. DATE OF DEATH Month 11 Day 1 Year 1960											
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1880		9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Records Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia + Septicemia DUE TO 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Suppurative Nephritis DUE TO (c) Purulent Cystitis												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----											
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----							
21. I certify that (I) (this hospital) attended the deceased from 1/12 to 11/1 19 60 , that (I) (we) last saw the deceased on 11/1 19 60 , and that death occurred at 2:05 A. M. from the causes and on the date stated above.															
22a. SIGNATURE L. Benedict, M. D.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS Crownsville State Hospital, Maryland				22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. DATE 11/1/60					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10/5/60		23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY		23d. LOCATION (City, town, or county) Cedar Hill, Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson				ADDRESS 1000 Branthay Ave.				25a. REC'D BY REGISTRAR NOV 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank					

12107

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12194

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Laurel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL, NURSING HOME, OR INSTITUTION District Training School Children's Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leo Middle Van Last Look		4. DATE OF DEATH Month November Day 15 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1898
9. AGE (In years birthday) 62 yrs.		10. IF UNDER 1 YEAR: Months 62 Days 15 Hours 15 Min. 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? ---	
13. FATHER'S NAME Edward M. Van Look		14. MOTHER'S MAIDEN NAME Elizabeth P.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Children's Center, Laurel, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia, dehydration, malnutrition DUE TO (b) Epilepsy DUE TO (c) Mental retardation CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3255			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 5th, 1960 to Nov. 15th, 1960 , that I last saw the deceased alive on Nov. 14th, 1960 , and that death occurred at 12:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George T Economos		ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 11/15/60	
PHYSICIAN'S NAME (Type) George T. Economos, M.D.		Children's Center, Laurel, Md. 11/15/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 16, 1960	
22c. NAME OF CEMETERY OR CREMATORY District Training School		22d. LOCATION (City, town, or county) (State) Laurel Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Welton		ADDRESS District Training School	
24a. REC'D BY REGISTRAR DATE NOV 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
12195												
12167												
1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Riva				c. LENGTH OF STAY IN 1b rural Mayo				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Mayo				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Riva				d. STREET ADDRESS rural Mayo				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM C. WARD				4. DATE OF DEATH Month Day Year November 27 1960								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 29, 1928		9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Operator				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) MAYO MD.		12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME WHEATLEY E. WARD SR.				14. MOTHER'S MAIDEN NAME IVA MAE WITT								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes Korean				16. SOCIAL SECURITY NO. Korean		17. INFORMANT BEATRICE A. WARD # 2		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries 866X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Crash								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:00 2:00 Nov. 27 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) field		20f. (City or town) Riva		(County) (State) Anne Arundel Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Charles S. Petty				EXAMINER'S NAME (Type) Charles S. Petty				M.D. Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/27/60
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11-30-1960		22c. NAME OF CEMETERY OR CREMATORY MAYO MEM. CEM.		22d. LOCATION (City, town, or country) (State) MAYO MD.				
23. FUNERAL DIRECTOR JOHN M. TAYLOR, SON ANNAPOLIS						ADDRESS ANNAPOLIS		24a. REC'D BY REGISTRAR DATE NOV 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12196

12168

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 7 years 1 mo. 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laystonville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsie Middle E. Last Warfield				4. DATE OF DEATH Month 11 Day 24 Year 1960					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887			
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington, D. C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration and Inanition DUE TO (c) Senility								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arteriosclerotic Cardiovascular Renal Disease and Chronic Brain Syndrome Due to Arteriosclerosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			
20f. (City or town) -----				20g. (County) -----		20h. (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 6/13 1960 to 11/24 1960 , that (I) (we) last saw the deceased alive on 11/24 1960 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Lionel McHenry Mapp				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 11/28/60			
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/60		23c. NAME OF CEMETERY OR CREMATORY Brookside Grove		23d. LOCATION (City, town, or county) (State) Laystonville Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville Md.		25a. REC'D BY REGISTRAR DATE DEC 5 '60			
						25b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12158

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12169

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Odenton Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mae Dodd Watts		4. DATE OF DEATH Month Nov. Day 13 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 25 , 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME XXXXXXX Thomas Uhler		14. MOTHER'S MAIDEN NAME XXXXXXX Clara Burgess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Fulton Watts, Odenton, Md.	
17. INFORMANT Fulton Watts, Odenton, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19 55 to November 19 60 , that (I) (we) last saw the deceased alive on 11-7 - 1960 , and that death occurred at 2A M., from the causes and on the date stated above.			
22a. SIGNATURE Charles R. MacDonald M.D. M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) O. R. MacDonald, M.D.		22d. ADDRESS 204 Crain Hghy SW, Glen Burnie	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 11/16/60	
23c. NAME OF CEMETERY OR CREMATORY Epiphany Church Cem.		23d. LOCATION (City, town, or county) (State) Odenton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		25a. REC'D BY REGISTRAR NOV 17 '60	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Knead	

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1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Riva			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herbert		First CARL		Middle WICKSTROM		Last November 29 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1899	
9. AGE (In years last birthday) 61 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET N.Y. TEL CO		10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME CHARLES L. WICKSTROM		14. MOTHER'S MAIDEN NAME AUGUSTA LARSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Chester A. Wickstrom		Address 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACTABLE CONGESTIVE FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH 72 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BLEEDING DUODENAL ULCER							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the hospital attended the deceased from 11-26-60 to 11-29-60 that (I) (x) saw the deceased alive on 11-29-1960 , and that death occurred at 8:10 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Edward S. Beck		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/29/60			
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 71 Franklin St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 12-3-60		23c. NAME OF CEMETERY OR CREMATORY FERNCLIFF CENT.		23d. LOCATION (City, town, or county) (State) WHITE PLAINS N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		ADDRESS Sum Annapolis Md.		25a. REC'D BY REGISTRAR DATE DEC 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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12197

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>HA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>H.H.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DIC</i>		c. LENGTH OF STAY IN 1b <i>50</i> <i>Brooklyn</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>211 Hillcrest Cir.</i>		d. STREET ADDRESS <i>211 Hillcrest Cir.</i>	
3. NAME OF DECEASED (Type or print) <i>MARtha E. WOLFE</i>		4. DATE OF DEATH <i>11-19-60</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-30-73</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MD.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Ramos Miles</i>		14. MOTHER'S MAIDEN NAME <i>Rachel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Family - Same</i>	
17. INFORMANT <i>Family - Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>senile generalized arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 15, 1955</i> , to <i>Nov 14, 1960</i> , that I last saw the deceased alive on <i>11/8/60</i> , 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel Rubin</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>203 Putapsco Ave</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>11/23/60</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Meadowdale</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully - 130 E. Fort St.</i>		24a. REC'D BY REGISTRAR <i>NOV 23 60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15102

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		65		JAN 15 1880		BALTIMORE		MD		USA			
MARRIED		W		15		JAN 15 1880		BALTIMORE		MD		USA			
OCCUPATION		FARMER		15		JAN 15 1880		BALTIMORE		MD		USA			
EDUCATION		HIGH SCHOOL		15		JAN 15 1880		BALTIMORE		MD		USA			
RELIGION		METHODIST		15		JAN 15 1880		BALTIMORE		MD		USA			
CAUSE OF DEATH		HEART DISEASE		15		JAN 15 1880		BALTIMORE		MD		USA			
MANNER OF DEATH		NATURAL		15		JAN 15 1880		BALTIMORE		MD		USA			
DATE OF DEATH		JAN 15 1945		15		JAN 15 1880		BALTIMORE		MD		USA			
PLACE OF DEATH		BALTIMORE		15		JAN 15 1880		BALTIMORE		MD		USA			
CITY		BALTIMORE		15		JAN 15 1880		BALTIMORE		MD		USA			
STATE		MD		15		JAN 15 1880		BALTIMORE		MD		USA			
COUNTRY		USA		15		JAN 15 1880		BALTIMORE		MD		USA			
SIGNATURE OF DECEASED				15		JAN 15 1880		BALTIMORE		MD		USA			
SIGNATURE OF WITNESS				15		JAN 15 1880		BALTIMORE		MD		USA			
SIGNATURE OF PHYSICIAN				15		JAN 15 1880		BALTIMORE		MD		USA			
SIGNATURE OF CLERK				15		JAN 15 1880		BALTIMORE		MD		USA			

15102

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT. IT IS TO BE DESTROYED AFTER FIFTY YEARS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12198

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12172

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade, c. LENGTH OF STAY IN 1b 4 mons.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		d. STREET ADDRESS Dunrovin Trailer Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STEPHEN Middle L Last WILCOX JR		4. DATE OF DEATH Month NOVEMBER Day 22 Year 19 60	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 June 1925
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) Elmira, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1947 to date		16. SOCIAL SECURITY NO. 129-16-2922	
17. INFORMANT Personnel Records Ft Geo G. Meade, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 578X DUE TO blood loss Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Upper gastro intestinal bleeding (b) Renal shutdown (c) Other significant conditions contributing to death but not related to the terminal disease condition given in Part I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 Nov 19 60 to 22 Nov 19 60 , that (I) (we) last saw the deceased alive on 22 Nov 19 60 , and that death occurred at 9:35 AM from the causes and on the date stated above.			
22a. SIGNATURE Howard Bob Mass M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 22 Nov 60	
22c. PHYSICIAN'S NAME (Type) HOWARD BOB MASS, Capt., M.C.		22d. ADDRESS USA Hosp Ft Geo G, Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 25, 1960	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Ray B. W. Overton, Funeral Home, Inc. 6306 Belair Rd, Baltimore - 6, Md.		25a. REC'D BY REGISTRAR DATE NOV 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thane			

15138

U.S. DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.

15138

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MADE IN U.S.A.

12173

12199

CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION	1. PLACE OF DEATH o. COUNTY <i>A.A.</i>		MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i>		b. COUNTY <i>AD</i>			
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BROOKLYN</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X BALTO.</i>					
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4405 Ritchie Hwy.</i>				d. STREET ADDRESS <i>1 4405 Ritchie Hwy.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
	3. NAME OF DECEASED (Type or print) First <i>HARRY</i>		Middle <i>W.</i>		Last <i>WOOD</i>		6. DATE OF DEATH Month <i>11-</i> Day <i>15-</i> Year <i>1960</i>			
	5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-24-98</i>		9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UPholsterer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>			12. CITIZEN OF WHAT COUNTRY?		
	13. FATHER'S NAME <i>John WOOD</i>				14. MOTHER'S MAIDEN NAME <i>ANNIE HANCOCK</i>					
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>25-10-7331</i>		INFORMANT <i>FAMILY</i>		Address <i>Same</i>			
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>420</i> IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) <i>Coronary Artery Disease</i> DUE TO (c) <i>1 year</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Gastric Ulcer - duration (?)</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <i>11/12</i> , 19 <i>60</i> to <i>11/15</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>11/13</i> , 19 <i>60</i> , and that death occurred at <i>2 A</i> .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1226 Hanover St</i> DATE SIGNED ACTUAL SIGNATURE <i>Harry Deibel</i> M.D. <i>Balto 30 Ind</i> PHYSICIAN'S NAME (Type) <i>DR. HARRY DEIBEL</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>SS</i>		22b. DATE THEREOF <i>11-19-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Burnie, MD.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Home</i>				ADDRESS <i>130 E Fort Ave</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 17 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 28 Monroe Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ABE		First FRANK		Middle ZELKOWITZ		Last November 3 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 18, 1894	
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Prop.		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery Store		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Zelkowitz		14. MOTHER'S MAIDEN NAME Sarah Block					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs Goldie Zelkowitz- Wife- Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Acute coronary occlusion DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min 1 hr					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/3 1960 to 11/3 1960 , that (I) (we) last saw the deceased alive on 11/3 1960 , and that death occurred at 2:00 PM , from the causes and on the date stated above		22a. SIGNATURE Richard N. Peeler		22b. DATE SIGNED 11/3/60			
22c. PHYSICIAN'S NAME (Type) RICHARD N. PEELER		22d. ADDRESS ANNAPOLIS, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 4, 1960		23c. NAME OF CEMETERY OR CREMATORY Kneseth Israel Cemetery		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland		25a. REC'D BY REGISTRAR NOV 7 '60		25b. REGISTRAR'S SIGNATURE Cochran & House	

1. *Chrysomelids*

John J. Conroy

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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Figure 1. Sample of a 100-item test.